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2012-02-21 10:14 DC0547PM13501 LEANING OF HEALTH AND HUMAN SERVICES 8652125642 >> 6158650321 P 4/22 CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES FORM APPROVED (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AND PLAN OF CORRECTION OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A BUILDING COMPLETED B. WING 445047 NAME OF PROVIDER OR SUPPLIER 02/14/2012 IMPERIAL GARDENS HEALTH AND REHABILITATION STREET ADDRESS, CITY, STATE, ZIP CODE 306 W DUE WEST AVE MADISON, TN 37115 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG PREFIX COMPLETION DAYE DEPICIENCY F 000 INITIAL COMMENTS This Plan of Correction F 000 affirms our allegation of During the recertification survey and complaint compliance for the investigation (#00029279), conducted on February 12-14, 2012, at Imperial Gardens deficiencies cited, Health and Rehabilitation, no deficientes were however, submission of cited under 42 CFR PART 483.13, Requirements this Plan of Correction is for Long Term Care for the complaint. not an admission that a deficiency exists or that one was cited correctly. F 246 483.15(e)(1) REASONABLE ACCOMMODATION This Plan of Correction SS=D OF NEEDS/PREFERENCES F 246 has been respectfully developed and submitted ; A resident has the right to reside and receive as required for compliance services in the facility with reasonable accommodations of individual needs and with federal and state preferences, except when the health or safety of regulations. the individual or other residents would be endangered. Resident #1 was immediately assessed per nursing staff for any This REQUIREMENT is not met as evidenced physical/mental injury, with no issues identified. Based on medical record review, observation Resident request was and interview the facility failed to ensure call lights identified and completed, where answered timoly for three residents (#1, #23, #24) of twenty-five residents reviewed. Residents #23 and #24 were immediately assessed by The findings included: nursing staff and the needs Resident #1 was admitted to the facility on of the residents were January 9, 2012, with diagnoses including addressed. Pneumonia, Muscle Weakness, Chronic Kidney Disease, Dysphagia, and Edema. All facility residents have the potential to be affected Review of the Minimum Data Set, (MDS) dated and can benefit from January 16, 2012 revealed the resident to be cognitively intact, and requiring assistance with corrective action. UDGRATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE TITLE (XG) DATE

by deficiency statement ending with an asterisk (*) denotes a deficiency which the insultation may be excused from correcting providing it is determined that its date of survey whether or not a plan of correction is provided. For nursing homes, the findings stated above are disclosable 90 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

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Event ID: J2KC11

Facility ID: TN1912

if continuation shoet Page 1 of 15

DC0547PM13501

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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TATEMEN	T OF DEFICIENCIES	TOWN PROJECTION SERVICES			FOR	MAPPROV
ND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILD (No	PLE CONSTRUCTION	(X3) DATE COMP	O. 0938-0: SURVEY LETED
		445047	D. WING			ų.
AME OF F	PROVIDER OR SUPPLIER	11047	1		020	14/2012
MPERIA	L GARDENS HEALT	H AND REHABILITATION	30	EET ADDRESS, CITY, STATE, ZIP C 16 W DUE WEST AVE	ODE	1-112012
(X4) ID PREFIX		TEMENT OF DEFICIENCIES	1) 160.	ADISON, TN 37115		
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F 246	Continued From pa	gg 1				1
į	activities of doily is	96 /	F 248	On 2/22/12, 2/23/12,		
!	transfers.	ng, ambulation, toileting, and	!	2/27/12, 2/28/12, 3/2/	/10 4	
			1.1	3/5/12 an all staff me	rz, and	
. :	Interview with the re	sident on February 12, 2012,		will be conducted by	th.	1
				Director of Nursing to	nie vin	
			i i	service the staff on the	ρ.	í Í
	THE WHILE CHUSED	me to lay in the bathroom a	1 1	facility expectation th	at all	:
!	long time".		1 1	stall answer call light	334	
1	Introduction of			requests within at leas	ta3	
1,	The view with Certifi	ed Nurse Technician (CNT)	1 1	minute time frame.		
			1 1		i	
			1 1	The Director of Nursin	ng j	
İs	resident's bathroom	as found on the floor of the	1 1	(DON) and/or designe	e will	
: i	nterview revealed	by CNT #2. Continued pon arrival to the unit at		assign a member of the	3	
				management team to		
			1 1	conduct call light drills	;	
			1	consisting of at least 2	per	
	The state of the s	T M OF COMME MAIL - 4 - 4.		Shift and a minimal of	5	
			1 1	times per week. This w	rill	
100	TACCHED CIAI TEN BLU	Vod in the secile in	1 1	continue for six weeks	then	
			1 1	randomly for at least tu	vo i	
			1 1	months.		
			1 1			
			1 1	Call light drills will con	sist	
	urse. The resident w	as not injured.	1 1	of a manager entering a		
R	eview of facility does	ments "Statement Form"		room putting on the call	light	
re	vealed "when I d	ame in around 7, I seen a		and timing staff respons	ie.	
				The answer time will be	j	
ba	ath" (emergency light	t) "cause it was red when		recorded on the call ligh	ı	
110	ame in (resident	on) bathroom floorleft		drill form.		
sic	de no tecs reporte	d to me"				
: U0	orminued review of th	e facility's document "call			j	
1 "9	THE VENT COLOCULORS	DODUCTION TOOL OF SOUL LINES			1	1
	MARKET SHE LESDOUS	A times revented #	1 1			i
,	ared alarms 1 (num	, , , , , , , , , , , , , , , , , , , ,	1 1			

STATEMENT OF DEFICIE	NCIES	(A) PROVIDERSUPPLIERCLA	- I market		FOI OMB N	RM APE
	ON	DENTIFICATION NUMBER:	A BUILDING	PLE CONSTRUCTION	(X3) DATE	
NAME OF PROVIDER OR	CHECK	445047	B. WING		-	N.
		H AND REHABILITATION	STRI	SET ADDRESS, CITY, STATE, ZIP (02	2/14/20
			11	6 W DUE WEST AVE ADISON, TN 37115	,00 <u>0</u>	
PRÉFIX (EACH TAG REGULA	DEFICIENCE TORY OR	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	PREFIX TAG	PROVIDERS PLAN OF CI (EACH GORRECTIVE ACTIO CROSS-REFERENCED TO THI		COM
6 346 D	_			DEFICIENCY	EAPPROPRIATE	
alarm was tumed room) BAT minutes this was tumed room) BAT minutes this continued revealed, "arrival at 6:: present and soon as (had fallen in been in flet Director of not injured dithe bathroom call lights and call lights and Continued intilight was active cord, the nine response to the not timely. Resident #23 diagnoses incl History of Falls	reyion. to the ADC lights are to the ADC lights are to the ADC lights are to the Call lights are the Ca	tal time 19.3 minutes AVE 2/6/2012 7:09:58 AM (time di) 7:29:14 AM (time alarm DC (location resident #4's e (run time)19:30. (nineteen ade)" the facility's documentation e with again upon her stated there was no one n answering call lights as to the floor found patient proon floor the patient toid	F 246	Results of the call ligwill be presented by Director of Nursing of designee to the clinic meetings, and aggreg define any trends and presented by the Director Nursing or her design the Quality Assurance committee monthly for continued monitoring improvements.	the or her cal gated to discount of hee to c	3/30
S-2587(02-99) Provious Ve						

2012-02-21 10:15 DC0547PM13501 CETACINENT OF MEALIN AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES 8652125642 >> 6158650321 P 7/22 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION FORM APPROVED (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED A BUILDING NAME OF PROVIDER OR SUPPLIER 445047 B. WING IMPERIAL GARDENS HEALTH AND REHABILITATION STREET ADDRESS, CITY, STATE, ZIP CODE 02/14/2012 306 W DUE WEST AVE SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION) MADISON, TN 37115 PROVIDER'S FLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) TAG PREFIX COMPLETION DATE TAG F 246 Continued From page 3 resident was always understood and was always F 246 able to make needs known, Continued review of the Brief Interview for Mental Status (BIMS) revealed a score of 15 indicating cognitively intact. Observation on the 200 hall on February 13. 2012, at 5:15 a.m., revealed resident #23's call light was activated. Continued observation revealed the call light was not answered until 5:28 a.m. (a thirteen minute delay). Resident #24 was admitted to the facility with diagnoses including Legal Blindness, Congestive Heart Fallure, and Lower Limb Amputation. Medical record review of the MDS dated January 19, 2012, revealed the resident was always understood and was always able to make needs known. Continued review of the BIMS revealed a score of 15 indicating cognitively intact. Observation on the 200 hall on February 13. 2012, at 5:22 a.m., revealed resident #24's call light was activated. Continued observation revealed the call light was not answered until 5:27 a.m. (a five minute delay). Interview with the Charge Nurse present on the 200 hall, on February 13, 2012, at 5:28 a.m., confirmed the call lights were not answered Interview with the Interim Director of Nursing on February 14, 2012, at 8:40 a.m., in the Director's office, confirmed that call lights are to be answered within three minutes, F 318 483.25(e)(2) INCREASE/PREVENT DECREASE F 318

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Event ID: J2KC11

Facility ID: TN1912

if continuation sheet Page 4 of 15

2012-02-21 40:15

DC0547PM13501 DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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AND PLAN OF C	DEFICIENCIES ORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	LOING	ION (XX) DAT	RM APPROV 10. 0938-0 E SURVEY
7.6		445047	1 1		COM	PLETED
NAME OF PROV	TOER OR SUPPLIER	445047	B. WIN	IG		
IMPERIAL G	ARDENS HEALT	TH AND REHABILITATION		AND M DUE MEZ.	CITY, STATE, ZIP CODE	2/14/2012
PREFIX TAG	EUMMARY ST (EACH DEFICIENC REGULATORY OR	Atement of Deficiencies by Must be preceded by Pull Lec Identifying Information;	PREFD TAG		DER'S PLAN OF CORRECTION PRECTIVE ACTION SHOULD SE	COMPLET DATE
Base resis with appropriate with appropriate for our review The form of the fo	a limited range ropriate treatment of motion and rease in range of REQUIREMENT of motion and rease in range of REQUIREMENT of medical resident (#1; wed.) Sindings included the resident #12 was rest 24, 2011, with the resident work of the physician poer 25, 2011, mess and decreases	prehensive assessment of a must ensure that a resident of motion receives ent and services to increase d/or to prevent further of motion. IT is not met as evidenced record review, observation, ellity failed to provide a splint ellity failed to the facility on hidiagnosos including are of Knee Surgery, and early of Knee Surgery, and early progress notes dated revealed "has been having ased sensation in the left earling a splint on the left earling as splint on the left earling a splint on the left earling a splint on the left earling as splint earling as spli	F 3	Residen assessed departm the bene was dete would ne the resid the splin after the were rev Physician All reside splints an have pote and can b corrective All reside splints wi nurse sup ensure pre equipmen being utili protocol a audits will	at #12 was re- by the therapy ent for evaluation of effits of the splint. It ermined the splint of be beneficial for tent and the order for t was discontinued recommendations iewed with the n. ents with orders for ad/or special devices ential to be affected benefit from the action. ents with orders for ell be audited by the tervisor weekly to oper supportive t is ordered and ized per application and times. These t occur weekly f12 and then and	

2012-02-21 10:16 DC0547PM13501 DEPARTMENT OF HEALTH AND HUMAN SERVICES 8652125642 >> 6158650321 P 9/22 CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION FORM APPROVED (X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER: OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A BUILDING 445047 B. WING NAME OF PROVIDER OR SUPPLIER IMPERIAL GARDENS HEALTH AND REHABILITATION 02/14/2012 STREET ADDRESS, CITY, STATE, ZIP CODE 306 W DUE WEST AVE SUMMARY STATEMENT OF DEFICIENCIES (EAGN DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID MADISON, TN 37115 PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD DE CROSS-REFERENCED TO THE APPROPRIATE PREFIX COMPLETION DATE TAG DEFICIENCY F 318 Continued From page 5 All new orders from the January 15, 2012, revealed ...splint left wrist F 318 previous 24 hour report will apply q (every) HS (night) and remove q am por be reviewed daily during the clinical meeting (which Interview with registered nurse #1 (RN) on includes the nurse February 13, 2012, at 5:00 a.m., in the hailway. supervisor, MDS nurse, verified the resident was to have a splint in place. Therapy manager, Social Worker, Dictary Manager, Observation and interview with resident #12 on Activity Director, and the February 13, 2012, at 6:04 a.m., revealed no DON). All orders involving splint was on and the resident stated had never splints and/or special devices had a splint for the wrist will be referred by the nurse supervisor to the therapy Interview with the Interim Director of Nursing department for evaluation (DON) on February 13, 2012, at 2:15 p.m., in the DON's office, confirmed the resident did not have and treatment a splint for the left wrist and revcaled the splint recommendations. had never been ordered. All issues identified will be presented by the DON or her designce at the At Risk F 323 | 483.25(h) FREE OF ACCIDENT meeting weekly for any SS=D HAZARDS/SUPERVISION/DEVICES interdisciplinary F 323 recommendations and The facility must ensure that the resident interventions. All results will environment remains as free of accident hazards he collected and presented as is possible; and each resident receives by the DON or her designee adequate supervision and assistance devices to to the Quality Assurance prevent accidents. committee monthly for continued monitoring and 3/30/12 improvement.

supervision to prevent falls, for one resident (#1) FORM CMS-2567(02-00) Previous Versions Obsolete

This REQUIREMENT is not met as evidenced

Based on medical record review, observation and interview, the facility falled to provide

Event ID: J2KC11

Facility ID: TN1912

If continuation shoot Page 6 of 15

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AND PLAN OF CORRECTION	1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		321 P 10/22 MB NO. 0938-039 DATE SURVEY	1
NAME OF PROVIDER OR SUPPLIER	445047	B. WING			COMPLETED	
IMPERIAL GARDENS HEALTH AN	ID REUADU III.	STR	EET ADDRESS, CITY, STATE,	7000	02/14/2012	
(AE) (D) CIMMANN			ADISON, TN 37115	ZIP CODE		7
TAG REGULATORY OR LSC ID	ENT OF DEFICIENCIES ST SE PRECEDED BY FULL ENTIFYING INFORMATION)	ID I	DECUMPENA		2 20	
	THIS INFORMATION)	PREFIX	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE!	THE SHOULD B	E COMPLETION UATE	
F 323 Continued From page 6	1		DEFICIE	NCY)	- Paric	
pharmaceuticale for	CONTRACTOR AND THE CONTRACTOR AN	F 323	F323			
pharmaceuticals for one five residents reviewed.	resident (#4) of twenty-		Resident #1 was	32		
			immediately asses	ssed per	1	1
The findings included:			nursing staff for a	ny	}	
Resident #1 was admitted			physical/mental in no issues identific	tiury, with	1 1	
January 9, 2012, with dia Pnoumonia, Muscle Wes	to the facility on		interventions were	u. Fall	1 1	
Pnoumonia, Muscle Wea Disease, Dysphagia, and	kness, Chronic Kidney		at that time.	mutated		
1			Resident #4's room	l Wac		
Review of the Minimum D. January 16, 2012 revealer	ata Set, (MDS) dated		inspected for any n	olonil	! !	
· Cognitively into at	une restrict to he		nazards. Supplies f	or the	j · 1	
activities of daily living, am	inng assistance with		wound care were n	Propaels:		
Transfers.	colleting, and		laneled and placed	in a	1 1	
Intendeursies	· ·	•	plastic bag and stor	ed in the	i - [
Interview with the resident at 10:32 A.M. in the reside tour revealed, the resident	"" - TOOM, Alleman Later		resident's closest sh	elf.		
tour revealed, the resident week" that "caused me to le	reported a fall "lust	1 1	All residents have the	ic		
week" that "caused me to la long time".	ly in the bathroom a		potential to be affect can benefit from cor	ted and		4
		11	action.	rective		
Interview with Certified Nurs	e Technician (CNT)					
1900 Wine Hallura	145 A.M., in the		On 3/2/12 and 3/5/12	a staff		
2012 the residenture	u on repruary 6.	11	meeting will be cond	Hutad		
resident's bathroom by CNT interview revealed upon	#2. Continued	11 .	by the Director of No.	TO I TO I		
interview revealed, upon arrivapproximately 7:00 A M. Ox	val to the unit at		"-scrvice the staff on	tha	1	
see, or locate other staff	1#2 was not able to		facility policy and pro	ocedure	1 1	
and began answering only 6-1	iners on the unit		and storage of resi	dent's		
activated, and noticed Reside	ing mat were		personal items and sup	200		
call light was activated. Furth	er interview	1 51	afficere in	0100000	cm	
revealed CNT #2 arrived in the 7:15 A.M. and found the resident	e resident's room at	1212	2 1/12 2/5	3. 1 31-		
, floor; at which time the Cata	ent lying on the	11 -10	-12/27, 713, (ence si	12012 ty 11	e 001
to the room, and removed the	resident from the	on t	2, 2/23, 3/5, a he requirement topoolde as	at theat	the Procesil	1
S-2567(02.00) D	Todani irom the	mies	+ provide as	sape, the	cene hom	'3
tS-2567(02-89) Provious Veralum Obsolete	Event ID: ARKO11	Facility up. 7		4	inal	1
			11 ~~	Melmorati .		
		Sa	nitary enviro	nment A	on are in	nido u
			U	0	ore one pa	VICEN

2012-02-21 10:16 VETARTIVIENT OF HEALTH AND HUMAN SERVICES DC0547PM13501 8652125642 >> CENTERS FOR MEDICARE & MEDICAID SERVICES 6158650321 P 11/22 FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: OMB NO. 0938-0391 (XZ) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A BUILDING COMPLETED NAME OF PROVIDER OR SUPPLIER 445047 B. WING IMPERIAL GARDENS HEALTH AND REHABILITATION 02/14/2012 STREET ADDRESS, GITY, STATE, ZIP CODE 300 W DUE WEST AVE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) MADISON, TN 37115 (X4) ID PREFIX TAG D PROVIDER'S FLAN OF CORRECTION PREELY (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG COMPLETION DEFICIENCY F 323 Continued From page 7 floor at 7:20 A.M. with the assistance of the The DON and/or designee F 323 nurse. The resident was not injured. will conduct room audits of at least 10 rooms, 5 times Review of facility documents "Statement Form" per week for six weeks to revealed, ..." when I came in around 7, I seen a ensure all supplies and lot of call lights going off Went to see about... personal items are properly bath" (emergency light) "...cause it was red when labeled and stored in a safe came in... (resident on) bathroom floor...left manner. Any issues side ... no tecs reported to me ..." identified will be corrected Continued review of the facility's document "call at that time and recorded on light audit" (electronic monitoring tool of call light a room audit form. activation and response times) revealed, "... The room audit forms will cleared alarms 1 (number of alarms responded to be aggregated and presented equaled one) "... total time 19.3 minutes ... AVE monthly by the Director of (Average) 19.3 min...2/6/2012 7:09:58 AM (time Nursing to the Quality alarm was activated) ...7:29:14 AM (time alarm was turned off)...LOC... (location resident #4's Assurance committee to room) BATH ...Rlime (run time) 19:30. (nineteen identify trends for minutes thirty seconds)" recommendations and continue monitoring. Continued review of the facility's documentation. revealed, " ... I spoke with ... again ...upon her arrival at 6:50 am ... stated there was no one present and ... began answering call lights as soon as ... came onto the floor... found patient had fallen in the bathroom floor ... the patient told ...been in floor ... "a long time"... IDON (Interim Director of Nursing)" Interview with the Assistant Director of Nursing (ADON) on February 12, 2012, at 3:40 P.M., in the ADON's office, confirmed the resident was not injured during the fall and the resident was on the bathroom floor for "nearly 20 minutes" Interview with the ADON on February 13, 2012, at 8:00 A.M., in the ADON's office, confirmed DRM CMS-2687(02-99) Previous Versions Obsolete Event ID: J2KC11 Fectily ID: TM1912

If continuation shoot Page 8 of 15

DC0547PM13501 DEPARTMENT OF HEALTH AND HUMAN SERVICES 8652125642 >> 6158650321 P 12/22 CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES FORM APPROVED (X1) PROVIDER/SUPPLIER/CLIA OMB NO. 0938-0391 AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A BUILDING COMPLETED 445047 B. WING NAME OF PROVIDER OR SUPPLIER 02/14/2012 IMPERIAL GARDENS HEALTH AND REHABILITATION STREET ADDRESS, CITY, STATE, ZIP CODE 306 W DUE WEST AVE SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY PULL
REGULATORY OR LSC IDENTIFYING INFORMATION) MADISON, TN 37115 PREFIX PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSC-REFERENCED TO THE APPROPRIATE TAG COMPLETION DATE TAG DEFICIENCY F 323 | Continued From page 8 bathroom call lights are considered emergency F 323 call lights and were to be answered immediately. Continued interview confirmed the bathroom call light was activated by use of an emergency pull cord, the nineteen minute thirty second delayed response to the call light on February 6, 2012 was Resident #4 was admitted to the facility August 17, 2011, with diagnoses including Closed Fracture of the Clavicte, Pressure Ulcer, Congestive Heart Fallure, General Ostecarthritis. and Coronary Artery Disease. Modical record review of the Minimum Data Set (MDS) dated January 7, 2012, revealed the resident had severe cognitive impairment, was bedbound, and required total assistance with all activities of daily living. Observation on February 12, 2012, at 10:30 a.m., in the resident's room, revealed the resident was in contact isolation. Further observation revealed sealed dressing supplies, a bottle of Betadine, and a bottle of Dakin's Solution 0.125%, prescribed to the resident, on the overbed table. Interview with LPN #1, at 10:35 a.m., in the resident's room, confirmed the dressing supplies and prescribed wound treatments were not to be in the room and should have been secured in the treatment cart. F 441 483.65 INFECTION CONTROL, PREVENT SS=D SPREAD, LINENS F 441 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission

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Event ID: 325011

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if continuation sheet Page 9 of 15

2012-02-21 10:17 DC0547PM13501

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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STATEMEN AND PLAN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDERISHED HERVELL	03/10/10		POR OMB NO	M APPROVE 0. 0938-039
		IDENTIFICATION NUMBER;	A BUILDIN	PLE CONSTRUCTION G	(X3) DATE	SURVEY
NAME OF	200	445047	B. WING)	
	PROVIDER OR SUPPLIER				02/	14/2012
		H AND REHABILITATION	11 -	EET ADDRESS, CITY, STATE, ZIP CO	DE	
(X4) ID PREFIX	SUMMARY STA	MUST BE PRECEDED BY FULL	10 1	ADISON, TN 37115	•	
TAG	REGULATORY OR L	SCIDENTIFYING INFORMATION	PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION SHOULD BE APPROPRIATE	COMPLETION DATE
F 441	Continued From pa	ne O				
19	of disease and infec	dian	F 441	F441		
	and allet	aion,		On 2/14/12 wound ea	mo for	
	(a) Infection Control	Program	1 1	resident #22 was con	ire for	1
	THE FACILITY MUST ACT	Shiek on Lat. 11		following facility pol	ion and	
İ	Program under which	h it -		procedure and CDC	icy and	
:	(1) Investigates con	trols, and prevents infections		guidelines,		l i
!	in the facility:	The province infections.	1 [g-wanen,		
ĺ	(2) Decides what pro	ocedures, such as isolation		All residents requiring	. 1	
ĺ	(3) Maintein applied to	an individual resident; and	1 1	wound care treatment	g	
	actions roles a recor	d of incidents and corrective	1 1	potential to be affecte	nave	
İ	actions related to infe	ections.	1 1	can benefit from corre	d and	
1.	(b) Preventing Sprea	w.e	+ 1	action.	ctive	
. , ,	III VVIIED TOO Intoxio	- 0	1 1	action.	i	
je	determines that a res	ident needs isolation to		On 2/22/12, 2/23/12, 3	V5110	
		infection, the facility must		3/7/12, and 3/9/12 a	75/12,	
i	solate the resident.	median, the facility must		mandatory in-services		
; (2) The facility must a	rohibit employees with a		be conducted by the D	Will	i
. 4	communicable diseas	e or Infected skin lesions		of Nursing to educate	rector	1
; ;	irect contact wi	th residents or their food, if	1 1	nursing staff on the fac	tll	- 1
16	irect contact will tran	smit the disease.		wound care policy and	ility	
h	ands after each at-	equire staff to wash their	1 1	procedure with focus of	1	- 1
ih	and washing is lodies	tresident contact for which	1 1	CDC infection control	n	1
P	rofessional practice.	accepted		practices.	ļ	
i i				1		Í
(0) Linens	i	11	A clinical skills check-	.00	
1 26	ersonnel must handle	, store, process and		will be completed on al	1	1
	insport linens so as t fection.	o prevent the spread of		nursing staff providing	· 1	
; ""	COLION.	1		wound care for compete		
!				using return demonstrat	io-	1
i		*		by the Director of Nursi	100	
Th	is REQUIREMENT .			for six weeks. The DON	ng	
		s not met as evidenced		and/or designee will con	disat	
₿a	sed on medical raco	rd review, observation,		wound care compliance	duct	
				rounds on at least three	.	1
fall	ed to maintain infecti	on control standards for		wound care dressing cha		1
		1	11	per week for six weeks.	nges	
AS-2567(02	-09) Pravious Versions Obsok	to Event ID: J2KC11		JON IN SIX WECKS,		. 1

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If continuation sheet Page 10 of 15

DC0547PM13501 DEPARTMENT OF HEALTH AND HUMAN SERVICES

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6158650321 P 14/22

AND PLAN	NT OF DEFICIENCIES OF CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIERICI IA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE	M APPRO O. 0938-0 SURVEY
			A. BUILDIN	IG	COMP	LETED
NAME OF	PROMDER OR SUPPLIER	445047	B. WING _		22	14/2012
		H AND REHABILITATION	11 3	REET ADDRESS, CITY, STATE, ZIP CO 06 W DUE WEST AVE	DE	1412012
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	IDI PREFIX TAG	PROVIDER'S PLAN OF COO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLET DATE
	Resident #22 was January 6, 2011, w Weakness, Urinary Hypotension and L blood ceil count). Medical record revideted January 20, 2 wound on left heel, wound cleanser: applied then cover with Kerl Observation on Feb in the resident's rooi (RN) #2 changed the left 5th loe, the left strevealed the nurse swaterless hand sand reriscisors from the nu observation revealed and retrieved the dirt fash can to the beds contaminated gloves or changing the gloves or changing the gloves teaned the wounds it terile applicator, discrete was supplicator, as supplicator.	duffing a dressing change. icd: admitted to the facility on of the diagnoses including Muscle of Tract Infection (UTI), eukocytosis (elevated white eukocytosis (elevated white eukocytosis (elevated white eukocytosis (elevated white eukocytosis (elevated white eukocytosis (elevated white eukocytosis (elevated white eukocytosis (elevated white eukocytosis (elevated white eukocytosis (elevated white eukocytosis (elevated white eukocytosis (elevated white eukocytosis (elevated eukocytosis (elevated eukocytosis elevated eukocytosis	F 441	The DON and/or desi Will Bresch the inform obtained from the work care observation round the Quality Assurance committee monthly for recommendations on a trends and continuous monitoring.	mation und ds to	3 30

DC0547PM13501 DEPARTMENT OF HEALTH AND HUMAN SERVICES

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AND PLAN	T OF DEFICIENCIES OF CORRECTION	E & MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENT/IF/CATION NUMBER:	(X2) MULTI A BUILDING	PLE CONSTRUCTION G	(X3) DATE	O. 0938-0 SURVEY PLETED
		445047	B. WING		-	
NAME OF P	PROVIDER OR SUPPLIER				02	114/2012
INDELIT	AL CARDENS HEALY	H AND REHABILITATION	38	HET ADDRESS, CITY, STATE, ZIP	CODE	
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAC	ADISON, TN 37115  PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CR033-REFERENCED TO THE	ON SHOULD BE HEAPPROPRIATE	COMPLE DATE
the state on ba	wiped sweat from a contaminated glove continued observation without sanitizing the opened a pack of 4 the Silvadene (ointrivound healing), and wounds without chathe hands. Observation of the hands without chathe hands without chathe hands without chathe hands without chathe hands with ken nurse applied 4x4 the wounds with Kentrevealed the nurse revealed the hands of the hands of the medication can the medication can the medication can the medication can nurse confirmed the ands or change the medication confirmed the cands or change the medication the medication the medication of placed in the medication of placed in the medication of placed in the medication washing the on other resident eview of facility policing Major Wounds, with veoled "set up such bedsidewash you wash you w	ninated gloves or wash the ervation revealed the nurse own forehead with the own forehead with the own forehead with the own forehead with the own forehead with the second of the hands or changing gloves, x4's, removed the cap from ment medication used for applied the ointment to the or changing the gloves or sanitizing attion revealed, without or changing the gloves, the sto each wound and wrapped flex. Continued observation emoved the soiled gloves, with a waterless hand witted the room, and placed ed 4x4's and wound cleanser in outside of the room.  In February 13, 2012, at way outside the resident's nurse falled to wash the contaminated gloves during Further interview with the contaminated cleaning ed from resident #22's room discretion and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and forestern and for	F 441	DEFICIENCY		

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STATEME AND PLAN	NT OF DEFIGIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIERGENA IDENTIFICATION NUMBER:	(X2) MULTIF	LE CONSTRUCTION	OMB NO	M APPROVE O. 0938-038 SURVEY LETED
		445047	a. WING		_	
	PROVIDER OR SUPPLIER				02	14/2012
		H AND REHABILITATION	11 00	ET ADDRESS, CITY, STATE, ZI G W DUE WEST AVE	PCODE	- 4420.72
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENC REGULATORY OR	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID: PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REPERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	COMPLETION DATE
F 465	Interview with the II (IDON), on Februar the DON's office, or not followed for a di control standards w	h bagput on new of dressing as orderedremove is bagwash your hands"  Interium Director of Nursing by 13, 2012, at 2:40 p.m., in anfirmed that facility policy was	F 465	F465 Resident #25's roccleaned and saniti	om was	
T R S A a Oth	residents, staff and interview, the factorist period interview, the factorist period interview, the factorist period interview, the factorist period interview, the factorist period interview, the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the fi	cord review, observation illy failed to maintain a in the resident's room for twenty five residents		All facility resider potential to be affican benefit by the action.  The DON will assi management team to conduct room roleast 10 rooms per minimal of 5 days for six weeks, with on the cleanliness a sanitary condition or resident's environm Staff was inserviced 2/23/12, 3/5/12, and by the Director of Non the requirement of facility must provide functional, sanitary, comfortable environ residents, staff and the same potential to the same point of the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same provided the same pro	gn a member sunds of at day for a per week a focus nd of the tent.  I 2/22/12, 13/7/12 lursing that the e a safe, and	

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Event ID: J2KC !!

Facility ID: TN1912

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If continuation sheet Page 13 of 15

DC0547PM13501 DEPARTMENT OF HEALTH AND HUMAN SERVICES

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6158650321 P 17/22

AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	PLE CONSTRUCTION	(XXX) DATI	VO. 0938-0 E SURVEY IPLETED
NAME OF	PROVIDER OR SUPPLIER	445047	B. WING		~	nii 1 Maa-
	AL GARDENS HEALT	H AND REHABILITATION	30	ET ADDRESS, CITY, STAYE, ZIP COI 6 W DUE WEST AVE	DE U	2/14/2012
PREFIX TAG	SUMMARY ST (EACH DEFICIENC REGULATORY OR	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS REFERENCE) TO THE A	fit	COMPLEY DATE
F 514 SS=D	of the bathroom. Fill member revealed "Further observation debris around the name of resident was seated to resident was seated to resident was seated to resident's room and brown colored debris reclined to telean.  483.75(I)(1) RES RECORDS-COMPLE  The tacility must main resident in accordant standards and practical accurately document systematically organism. The clinical record maniformation to identify resident's assessment services provided; the preadmission screeniand progress notes.  This REQUIREMENT y:  Based on medical record of facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facility failed to do facilit	n, brown colored debris was on a commode and the doorway urther interview with the family this is not uncommon." In revealed the brown colored esident's recliner where the esident's recliner where the family at 10:25 a.m., in the bathroom, confirmed the is in the bathroom and beside ar and the environment was exampled the error of the example of the contain sufficient are complete; and the resident; a record of the example of the plan of care and a results of any and conducted by the State; and contain sufficient is not met as evidenced and conducted by the State;	F 485	Information collected the results of the room rounds will be present the DON or her design discussed in the stammeetings. All informs will be collected and submitted by the DON designee to the Quality Assurance committee monthly for recommendations and continued monitoring.  F514  On 3/1/12 a complete review was completed Resident #1's medical review was completed Resident #1's medical report with information obtained off the incident investigation dated 2/16  All facility residents has potential to be affected as	d from moted by mee and d up ation  N or her ty  I  record on record ty Tall on the the the the the the ty the the ty the the the ty the the ty the the the the the the the the the the	3 30 1

2012-02-21 10:19 DC0547PM13501 DEPARTMENT OF HEALTH AND HUMAN SERVICES 8652125642 >> 6158650321 P 18/22 CENTERS FOR MEDICARE & MEDICAID SERVICES HELLU. VELLIEL STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION FORM APPROVED (X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER: OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 445047 NAME OF PROVIDER OR SUPPLIER 02/14/2012 STREET ADDRESS, CITY, STATE, ZIP CODE IMPERIAL GARDENS HEALTH AND REHABILITATION 306 W DUE WEST AVE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) MADISON, TN 37115 (X4) ID PREFIX IO PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROVILIATE TAG COMPLETION DATE TAG DEFICIENCY F 514 | Continued From page 14 can benefit from the F 514 The findings included: corrective action. Resident #1 was admitted to the facility on January 9, 2012, with diagnoses including The prior days 24 hour Pneumonia, Muscle Weakness, Chronic Kidney report will be reviewed by Disease, Dysphagia, and Edema. the nurse supervisors in the clinical meeting (the clinical Review of the Minimum Data Set, (MDS) dated meeting members are the January 16, 2012 revealed, the resident to be Director of Nursing, nursing cognitively intact, and requiring assistance with supervisors, Social worker, activities of daily living, ambulation, tolleting, and Dietary manager, Activity transfers. Director and Therapy manager. Any falls, Review of the facility's documentation revealed resident #1 sustained a fall with no injury on incidents, abnormal events for the prior day will be February 6, 2012. reviewed and discussed Review of the facility medical records "Nurses during the clinical meeting. Notes" revealed no documentation of the fall. The clinical record will be reviewed by the nursing Interview with the Interim Director of Nursing supervisor to ensure all (IDON) on February 12, 2012, at 3:40 P.M., in the documentation regarding the IDON's office confirmed the fall had occurred on February 6, 2012. Continued interview confirmed event/incident is present and accurate in the medical the facility had falled to document the fall. record Any issues identified in the clinical meeting will be documented and submitted

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Event ID: J2KCT

Facility ID: TN1912

If continuation sheet Page 15 of 15

by the Director of Nursing monthly to the Quality Assurance Committee for review, recommendations, and continued monitoring.